STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner
V **File No. 87866-001**

US Health and Life Insurance Company
Respondent
_____/

Issued and entered
This 12th day of May 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On February 15, 2008, the Commissioner of Financial and Insurance Regulation received a request from **XXXXX** (Petitioner) for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the information and accepted the request on February 22, 2008.

The Commissioner notified US Health and Life Insurance Company (USHL) of the external review and requested the information used in making its adverse determination. USHL provided the information and the case was referred to an independent review organization for analysis of medical questions presented by the petitioner's request for review. The IRO report was provided on March 5, 2008.

II
FACTUAL BACKGROUND

During the later stage of her pregnancy, Petitioner developed preeclampsia. She was taken

to Wyandotte General Hospital where it was recommended that she be moved to Oakwood Hospital in Dearborn which had a neonatal intensive care unit. On September 6, 2007 the Petitioner was transported by ambulance to Oakwood. Her baby was delivered on **XXXXX**. The baby weighed 2 pounds, 6 ounces at birth and required tube feeding. A breast pump was supplied so that Petitioner could provide the baby with breast milk. Petitioner was released from Oakwood on September 14. Because her blood pressure was not at a normal level, Petitioner was discharged with a blood pressure monitor. Respondent initially declined to provide coverage for the billed amount of the ambulance transfer and declined to provide any coverage for the breast pump and the blood pressure monitor.

Petitioner appealed. USHL reviewed the claims, agreed to provide coverage for the monitor, but upheld its determination with respect to the ambulance and breast pump. USHL sent a final adverse determination to the Petitioner dated March 8, 2007.

III
ISSUES

1. Is USHL required to provide coverage at its in-network level for the Petitioner's ambulance service?

2. Is USHL required to provide coverage for the breast pump?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says she was in "excruciating pain" and unable to move any part of her body when her mother called 911 on September 6, 2006. An ambulance from the Southfield Fire Department responded and took her to the nearest hospital where tests showed she had a ruptured ovarian cyst. The charge for the ambulance service was $589.00. USHL paid $132.30, leaving the Petitioner owing a balance of $456.70.

The Petitioner was unable to drive to the hospital and says she had no choice but to call

911, the standard procedure in an emergency. She wants USHL to reconsider its decision to process the claim as an out-of-network benefit and pay more for the service. Petitioner also argues that the breast pump was medically necessary because she could not feed her baby directly while the baby was in the neonatal intensive care unit.

US Health and Life Company's Argument

According to USHL, under the terms of the Petitioner's certificate, out-of-network services are subject to a $500.00 per person annual deductible and then paid at 70% of the reasonable and customary charge for the service. The Southfield Fire Department is not part of USHL's network so the ambulance service was subject to a higher deductible and coinsurance.

Regarding the ambulance service, USHL stated in its February 20, 2008 letter to the OFIS:

> The benefit amounts payable are based on the network status of the providers. Benefits are not based on the effort of the [insureds] in attempting to obtain services from network providers or on the reasons they do not, such as an emergency. The insured is not required to use the services of any one particular provider. There is no special handling for out-of-network emergencies.
>
> In-network and out-of-network benefits are different because of the discounts US Health and Life receives when an insured person receives treatment from a network provider. These discounts are not available from non-network providers. Policy benefits are based on whether a provider is in the network and provides a discount or is out-of-network. Benefits are not based on the availability of providers.

In the same letter, USHL addressed the breast pump claim:

> While it is correct that [Petitioner] required a breast pump in order to provide breast milk to her newborn child, who as a prematurely born infant was placed in NICU, there has been no indication provided to USHL that there was any medical necessity for breast feeding. Breast feeding versus bottle/formula feeding is a lifestyle choice. The breast pump does not treat any illness or injury.

Commissioner's Review

The Commissioner has reviewed the arguments and documentation of the parties as well as the certificate. The Commissioner's role in this case is to determine whether the Petitioner was

incorrectly denied benefits under the terms and conditions of the certificate.

The Commissioner concludes that USHL correctly processed the claim for ambulance service. The Petitioner's certificate includes coverage for ground or licensed air ambulance services for emergency or medically necessary transportation. It is understandable that the Petitioner called 911 when she needed an ambulance in an emergency, and it is unfortunate that the circumstances did not permit her to choose an in-network ambulance provider. Nevertheless, USHL is correct when it says that it pays benefits according to the network status of the provider. The Commissioner can find nothing in the certificate (or in state law) that would require USHL to make an exception when an out-of-network ambulance is dispatched following a 911 call (or in any emergency situation), or even when no network ambulance provider is available at all. USHL bases its level of coverage on whether the provider is in or out of its network. Based on this analysis, the Commissioner concludes that USHL correctly process Petitioner's ambulance claim.

The breast pump claim raised the issue of medical necessity. For that reason it was submitted to an independent review organization (IRO) as required by section 11(6) of the PRIRA. MCL 550.1911(6). The reviewer is a physician Board-certified in neonatology and child neurology who hold an academic appointment and has been in practice for more than 10 years. The reviewer, after examining the medical records submitted by Petitioner and Respondent in this case, concluded that the breast pump was medically necessary, due to the fact that the Petitioner's infant was born at 29 weeks gestation and providing breast milk to a premature infant is medically important.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO recommendation is afforded deference by the Commissioner; in a decision to uphold or reverse an adverse determination the Commissioner must cite "the principal reason or reasons why the commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16) (b) The IRO's analysis is based on extensive experience,

expertise, and professional judgment. The Commissioner can discern no reason why that judgment should be rejected in the present case. Therefore, the Commissioner accepts the findings of the IRO that the breast pump is medically necessary and should be covered by USHL.

V
ORDER

The Commissioner upholds USHL's adverse determination regarding the ambulance service. USHL is not required to pay more for the Petitioner's ambulance services on September 6, 2006. The Commissioner reverses USHL's denial of coverage for the breast pump. USHL is required to provide coverage for Petitioner's breast pump subject to any applicable deductibles or co-payments.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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Ken Ross
Commissioner